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UNITED STATES DEPARTMENT OF AGRICULTURE
Farm Security Administration
Raleigh, N. C.

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TO: All State Directors

Copies to: All State, District, and County Personnel

FROM: J. B. Slack, Regional Director
Region IV

SUBJECT: The Role of Health Services in the FSA Program

At the recent national conference of Regional Health Services personnel, during which consultations with representatives of other FSA divisions and other Department bureaus were held, there was constant emphasis on the need for more effective integration of all rehabilitation services. The recommendations which came from this conference afford me timely opportunity to emphasize the necessity for maximum integration of health services in the total rehabilitation program at every level of administration. Provision for health services and health education must be as vital a part of the farm and home planning as are provisions for secure tenure, improved farm and home practices, and adequate credit. Illness is a major concern of every borrower family, and these families cannot be successfully rehabilitated while their health needs go unmet. Certainly no program of security for rural people can neglect the implications of poor health.

To insure satisfactory and enduring rehabilitation for that segment of the rural population we serve, there must be the fullest possible coordination of all phases of our program which affect borrower families. In order to further this objective, the Health Services Division has been placed under the direction of the Assistant Administrator in charge of the Rural Rehabilitation and Farm Ownership Divisions.

Our objective is to help every borrower family attain good health. It will be your responsibility to help achieve this goal by insuring to the extent possible that our supervisory activities at State, district, and county levels include the following:

1. Adequate provision in the farm and home plan to meet health care expenses (a) on an individual basis and (b) by participating in a group prepayment plan, where possible.

2. Provision in farm and home planning for a protected water supply, sanitary waste disposal, insect and rodent control, and a safe farm and home environment.

Significant improvements in each of these phases of health protection

can be achieved with the expenditure of little or no funds by utilization of the family labor and materials at hand. No degree of success will be likely, however, unless the families are made to recognize these deficiencies and to desire to correct them.

3. Encouraging the full use by borrower families of all community health services available through public and private agencies. Health services of many types can readily be made available to borrower families at little or no cost through such agencies as district and county health units, the Department of Vocational Rehabilitation, Maternal and Child Welfare clinics, Crippled Children's Bureau, and many local civic, church, and farm group organizations.

4. Education of families to recognize their needs and to seek to improve their health through such means as better nutrition, improved individual and family health practices, and participation in community health activities.

In order that there may be better appreciation of the relation of health to rehabilitation, and to insure that the supervisory activities outlined above become an integral part of county programs of work, it will be necessary to maintain continuing emphasis on these activities in all training programs. Members of FSA committees, as well as FSA personnel themselves, should have a thorough understanding of the part the health services program can play in rehabilitation.

Among the activities aimed at helping every borrower family attain good health, the prepayment medical care plans require special mention. The impact of the war on our prepayment medical care plans retarded the extension of the benefits of such plans to borrower families in several states. Despite their limitations, they represent one of the most effective tools at our command to assure borrower families needed medical services and a considerable degree of security against the unpredictable costs of sickness. The low rate of participation of eligible borrowers in these plans even where the program is in active operation is a cause for real concern. Every opportunity should be sought to extend this program into new areas, to reestablish it where it has lapsed, to foster the participation of far more borrowers in existing plans, and to strengthen generally the entire program.

Experience has shown that the establishment of multi-county or state-wide medical care plans, by broadening the membership base, will avoid some of the weaknesses inherent in plans confined to single-county areas. It would be well to place emphasis on the organization of such plans as a means of strengthening the base on which the health associations operate. The development of plans offering more inclusive services is also a forward step. And perhaps most important of all, every opportunity should be taken to stimulate more active participation by the members in planning and administering their own programs.

The experience gained through use of the prepayment medical care plan indicates that its greatest value is in the field of corrective medicine, and

that, at least for the present, its use alone is not providing even a minimum standard of preventive care that is essential to the rehabilitation of the families with which we work.

In order to provide each borrower family with the well-rounded health protection that is essential to their rehabilitation, no farm and home plan should be completed without a thorough appraisal of the health needs of the family being made, and provisions being included in the plan for correction of the deficiencies to the greatest degree possible through such methods as are indicated herein.

G. B. Slack